Little Rock Community Mental Health Center, Inc.
AUTHORIZATION FOR DISCLOSURE OF INFORMATION

Patient's Name: Date of Birth:

I hereby request and authorize Little Rock Community Mental Health Center, Inc. (LRCMHC) to, as indicated below, release and obtain from:

Name:

Address:

City, State: Zip Code:

the following information pertaining to myself to be disclosed: *(Patient must initial boxes checked)*

OBTAIN	RELEASE		
☐ ________	☐ ________	All health information relating to the following treatment, condition or dates of treatment: ____________	
		Only health information relating to the following items *(If any of the following items should be limited to a specific timeframe, please indicate the date(s) in the blank provided.)*	
☐ ________	☐ ________	Presence in treatment/service	________
☐ ________	☐ ________	Medical history and physical exams	________
☐ ________	☐ ________	Intake assessment	________
☐ ________	☐ ________	Psychological tests and reports	________
☐ ________	☐ ________	Psychiatric evaluations	________
☐ ________	☐ ________	Medication history	________
☐ ________	☐ ________	Treatment plans	________
☐ ________	☐ ________	Results of drug screens	________
☐ ________	☐ ________	Diagnosis(es)	________
☐ ________	☐ ________	Description of progress	________
☐ ________	☐ ________	Discharge summary	________
☐ ________	☐ ________	Other: ________	________

This information is needed for the following purpose(s): *(Patient must initial boxes checked)*

- ☐ ________ To complete an evaluation
- ☐ ________ To provide treatment/service/continuing care
- ☐ ________ To coordinate treatment with my family/significant others/concerned persons
- ☐ ________ To coordinate treatment/service with other treatment/service providers
- ☐ ________ For legal representation/proceedings
- ☐ ________ To comply with a Court Order/Supeona
- ☐ ________ For my personal files
- ☐ ________ To assist with Social Security Disability Determination
- ☐ ________ For insurance application and/or claim
- ☐ ________ At my request as a patient
- ☐ ________ Other: ____________

I authorize this information to be disclosed in the following format:

☐ Verbal ☐ Written ☐ Facsimile ☐ Other: ____________

(Please complete reverse side of Authorization)

Expiration Date: This Authorization expires on: (after one year from date signed);
(Date)

or, when the following event occurs:

1. I understand that this authorization is voluntary. I understand that if the organization authorized to receive the information is not a health plan or healthcare provider, the released information may no longer be protected by federal privacy regulations.

2. I understand I have the right to refuse to sign this authorization and that my refusal will not result in LRCMHC conditioning the provision of treatment, payment, health plan enrollment, or benefits eligibility on my giving authorization for the requested use or disclosure.

3. I understand that I may see and copy the information described on this form if I ask for it, except psychotherapy notes or other information that in the opinion of my LRCMHC physician may be detrimental to my health as provided in Ark. Code Ann. § 16-46-106.

4. I understand that I will receive a copy of this form once signed.

5. I understand that once the information described herein is disclosed, it may no longer be subject to the privacy protections afforded by LRCMHC if the recipient of the information is not a health plan, healthcare provider, health care clearinghouse, or a business associate that has a contract with LRCMHC.

6. I understand that the specific information to be disclosed may include history of or treatment of DRUG or ALCOHOL ABUSE; history of or treatments of MENTAL HEALTH CONDITIONS, or history of testing for or treatment for ACQUIRED IMMUNE DEFICIENCY SYNDROME (AIDS), or RELATED CONDITIONS.

7. I understand that LRCMHC will assess a reasonable fee for copying the records. LRCMHC will notify me of the total amount due for copying and shipping the requested records; I agree that LRCMHC will only send me the requested information once it has received payment in full for those costs.

8. I may revoke this authorization to the extent allowed by law, by notifying LRCMHC in writing (LRCMHC, Attention: Privacy Officer, 1100 North University, Suite 200, Little Rock, AR 72207) of my intent to revoke this authorization. I understand that any revocation will not have any effect on LRCMHC's actions taken before the revocation.

Legal authority to request:

______________________________	______________________________
Signature of Patient/Legal Representative	Date Signed
______________________________	______________________________
Printed Name of Patient/Legal Representative	Legal Authority if Signed by Representative
______________________________	______________________________
Signature of Witness	Date Witnessed

(If signed by Patient's legal representative, attach evidence of that authority, such as a Durable Power of Attorney; Letters of, or appointment of guardianship; or Letters Testamentary.)

My signature below indicates that I have received a copy of this completed Authorization:

____